SOUTH DAKOTA BOARD OF NURSING
UNLICENSED ASSISTIVE PERSONNEL
4305 S LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

UMA INITIAL REGISTRATION APPLICATION

If any of the information is incorrect, incomplete or illegible, processing may be delayed. An applicant will be notified if additional information is required. **Send this completed application to the address listed above or email to Ashley.Kroger@state.sd.us.**

***Allow up to 5-7 business days** for the SDBON to process your application, upon approval the BON will email the approved proctor the access information to allow you to take the SDBON online exam.**

Please Print

Name: First_____ Middle_____ Last _____

Other names previously used:_____

Mailing Address:_____ City_____ State_____ Zip_____
Street/PO Box

Telephone: Home: (___) _____ Cell: (___) _____ Other: (___) _____

Email: _____ **Date of Birth**:_____

Social Security #: _____ **Gender**: ❑Male ❑Female

Ethnicity: ❑Caucasian ❑Black ❑Hispanic ❑Asian/Pacific Islander ❑American Indian/Alaskan Native ❑Other

1. **High school education information or equivalency information.**

Name of High School or Equivalency Program	Location of School or Equivalency Program (City, State)	Year Diploma or Equivalency Received

2. **RN Attestation.**

I, _____, RN verify that the individual identified on this application has completed the SD Board of Nursing's approved 20-hour 20 hour Medication Aide Training Course, is capable of performing all skills listed on the SD Board of Nursing's Approved Skills Competency Checklist safely and competently, and is eligible to take the Medication Aide exam.

RN Signature: _____ **RN License #:** _____ **Date:** _____

3. **SD Board of Nursing Approved Test Proctor Information.**

Name of SDBON Approved Proctor:	Proctor's Phone:	Proctor's Email Address:

4. **Do you currently owe child support arrearages in the sum of $1,000 or more?** ❑YES ❑NO
If YES, contact South Dakota Department of Social Services to make arrangements prior to issuance of med aide registration.

5. **Affidavit**
I, the undersigned, declare and affirm under the penalties of perjury that this application for registration in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

_____ _____
Medication Aide Applicant Signature **Date**